DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

CENTER FOR SUBSTANCE ABUSE PREVENTION
CENTER FOR MENTAL HEALTH SERVICES

COOPERATIVE AGREEMENT FOR PARENTING AND FAMILY STRENGTHENING PREVENTION INTERVENTIONS: A DISSEMINATION OF INNOVATIONS INITIATIVE

Short Title: FAMILY STRENGTHENING

PART I - Guidance for Applicants (GFA) No. SP 00-002

Catalog of Federal Domestic Assistance No. 93.230

Under the authority of Section 501(d)(5) of the Public Health Service Act, as amended(42 USC 290aa), and subject to the availability of funds, the SAMHSA Center for Substance Abuse Prevention will accept applications in response to this standing Guidance for Applicants for a receipt date of June 13, 2000.

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Part I - PROGRAMMATIC GUIDANCE

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[Note to Applicants: In order to prepare an application, PART II, "General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements" (February 1999 edition), must be used in conjunction with this document, PART I, "Programmatic Guidance."]

Section I. OVERVIEW

Purpose

The Substance Abuse and Mental Health Services Administration (SAMHSA) announces the availability of cooperative agreements to support "Parenting and Family Strengthening Prevention Interventions: A Dissemination of Innovations Initiative." In efforts to move research to practice, knowledge must be disseminated and appropriately applied to specific populations. This initiative is a knowledge application program, designed within the conceptual framework of SAMHSA's Knowledge Development and Application (KD&A) mission. This initiative is funded as a partnership among SAMHSA's Center for Substance Abuse Prevention (CSAP) and Center for Mental Health Services (CMHS). The cooperative agreement mechanism is being used because the complexity of the program requires substantive involvement of Federal staff.

This program, hereinafter referred to as "Family Strengthening," solicits applications to: 1) increase the capacity of local communities to deliver best practices in effective parenting and family programs in order to reduce or prevent substance abuse, 2) document the decision-making processes for the selection and testing of effective interventions in community settings, and 3) determine the impact of the interventions on the target families within this study. It is anticipated that approximately 20-30 applications will be funded in FY2000 to participate in this two-year effort. Applicants will be selected on the basis of capacity to deliver family services and will be supported to select a culturally-appropriate, family-focused program that is best matched to their target population.

All grantees are expected to modify the program they select to further tailor interventions to heighten cultural-appropriateness and increase effectiveness for their local families. The selected intervention should maximize effectiveness in preventing or reducing alcohol, tobacco or other illegal drug use as well as associated social, emotional, behavioral, cognitive and physical problems of parents and their children. The need for a Family Strengthening initiative to reduce the early onset of substance abuse and behavioral health problems is intensified, in part, by the dramatic effects of youth violence over the past decade. In addition to this GFA, SAMHSA's youth violence prevention initiative supports several programs that provide Federal funds to communities to address youth development and the prevention of youth violence.

Eligibility

Applications may be submitted by domestic public or private non-profit and for profit entities, units of State and local governments, and community-based organizations, universities, colleges and hospitals.

Availability of Funds

Up to $2.5 million is available from SAMHSA/CSAP/CMHS to support these activities within the range of 20-30 awards under this GFA in FY2000. The average award is expected to be $80,000 to $100,000 in total costs (direct + indirect) per year.

Period of Support

Support may be requested for a period of 2 years. Awards for the second year will be made subject to continued availability of funds appropriated by Congress and grantee progress achieved.

Section II. PROGRAM DESCRIPTION

Program Summary

This initiative expects to determine: the major factors associated with effective dissemination of information that leads to the selection of the best evidenced-based model for specific populations; the factors that influence decisions in adopting, locally/culturally adapting, and implementing a family intervention model tailored for the particular target population; and which interventions continue to produce positive findings and behavioral health improvements when culturally modified and replicated by community-based systems of care that intervene with the target population. Additionally, this initiative will determine the effectiveness of current SAMHSA/CSAP family strengthening dissemination materials, and technical assistance and training efforts by circulating information on effective, family-focused, substance abuse prevention programs. Grantees will be expected to implement (field test) the program selected (with several cohorts, when applicable) in order to graduate a minimum of thirty families in a local community setting.

Background

Despite the recent debate about the importance of parents in a child's development (Harris, 1998), the critical role of family factors has been acknowledged in virtually every empirically-tested psychological theory of child development (Bandura, 1986). Family variables are a consistently strong predictor of antisocial and delinquent behaviors (Loeber & Stouthamer-Loeber, 1986; Tolan, Guerra, & Kendall, 1995) especially among minority youth (King, Beals, Manson, & Trimble, 1992). According to a recent analysis of 8,500 high-risk youth from CSAP's High Risk Youth Cross-Site study, the strongest pathway protecting youth from drug use involves positive family relations, leading to improved supervision and monitoring, and anti-drug family and peer norms. Hence, family interventions that decrease family conflict, improve family involvement, and increase

parental monitoring should reduce later youth problem behaviors and alcohol and drug abuse and decrease early conduct disorders (Nye, Zucker, & Fitzgerald, 1995). The probability of a youth acquiring developmental problems increases rapidly as risk factors increase in comparison to protective or resilience factors (Dunst & Trivette, 1994; Rutter, 1990). Hence, increasing family protective mechanisms and individual resiliency processes should be addressed in addition to reducing family risk factors.

Family Protective and Resilience Factors. Throughout the research on traits of resilient individuals, it is evident that there are various resilience-enhancing processes which go on in families. Virtually all of these resilient families report some combination of caring relationships, high expectations and support, and opportunities for the children to be contributing members of the family from early on in life. According to Bry and associates (1998), the five major types of protective family factors include:

1) supportive parent-child relationships,

2) positive discipline methods,

3) monitoring and supervision,

4) family advocacy for their children, and

5) seeking information and support for the benefit of their children.

Similarly, Garmezy (1987) noted that "positive family attributes" include "such elements as quality of the parent-child relationship, adequacy of family communication, degree of parents' perceptiveness about the child, and overall competence of the parent." Family stability, organization, and cohesion also serve as protective factors, and that children with these more advantageous family characteristics were more intelligent, more competent, and less likely to become disruptive under high levels of stress.

It is clear that these general protective family factors cut across race/ethnicity. For example, Garmezy (1991) lists nine factors and Clark (1983) identified a series of factors that characterized families of high achieving, poor children which include:

1. Frequent school contacts initiated by parents.
2. The child has exposure to stimulating, supportive school teachers.
3. Parents expect to play a major role in the child's schooling and expect the child to do likewise.
4. Parents establish clear, specific role boundaries and status structures while serving as the dominant authority.

5. Conflict between family members is infrequent.
6. Parents frequently engage in deliberate achievement-training activities.
7. Parents exercise firm, consistent mentoring and rules enforcement.
8. Parents provide liberal nurturance and support.
9. Parents are able to defer to the child's knowledge on intellectual matters.

Across the various listings that exist, it is clear that key protective factors in families are the perceived availability of parental emotional and instrumental support. In a study of 1,702 seventh to ninth graders (12-15 year olds), Wills and Cleary (1996) found that perceived support was inversely related to the adolescents' use of alcohol, tobacco, and marijuana. Support was found to be a mediator variable, both reducing the impact of risk factors (e.g., deviance-prone attitudes, negative peer affiliations, and behavioral under control) and enhancing the effect of protective factors (e.g. more positive behavioral coping abilities and academic competence). Resiliency research also suggests that encouraging parents to support their children in developing dreams, goals, and a purpose in life is also an important protective factor (Walker, Kumpfer, & Richardson, 1997).

The challenge to family intervention researchers is to develop and test interventions that effectively address a broad range of family protective factors that prevent multiple youth behavioral health problems (Elliot, Huizinga, & Menard, 1989; Jessor, 1993). Effective family strengthening programs recommended for this program were selected from the various professional sources listed in Appendix C. Additional background information on Family Strengthening is in Appendix F.

Target Population

This program targets families at risk for substance abuse and related behavioral health problems including, but not limited to conduct disorders, learning disabilities and/or aggressive behavior. The term "Family" in this GFA does not refer only to biological parents, but also includes step-parents, adoptive parents, foster parents, extended family, and other combinations of family members. The target population is not restricted on the basis of age of caretakers, or race/ethnicity. Any at-risk population can serve as the target population for this project. Specific target populations could include, but not necessarily be limited to: families where one or both parents are or have been substance abusers; families with children who exhibit conduct disorders, learning disabilities or aggressive behavior; families with disabled children; families with children at critical developmental transitions; immigrant families; adolescent parents; foster care children and their families; and homeless families.

Program Plan

Goals
The goals of this parenting and family strengthening project are to determine:

1) The major factors associated with effective dissemination of information that lead to the selection of the best evidence-based model for specific populations;

2) The factors that influence decisions in adopting, culturally and locally adapting, and implementing a family intervention model tailored for the target population;

3) The family interventions that continue to produce positive findings and behavioral health improvement when culturally modified and replicated by community-based systems of care that intervene with the target population.

Methodology, Data Collection, Analysis and Performance Monitoring

Applicants must describe in detail how they plan to evaluate their projects to determine whether or not they meet their goals, document their projects to ensure fidelity and validity, as well as describe the process and outcome data collection procedures. For this purpose, they must use and describe the appropriate measures from the CSAP Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs Questionnaire as approved by the Office of Management and Budget under control no. 0930-0208. This CSAP GPRA Questionnaire includes two separate instruments, the Adult Tool and the Youth Tool. The adult tool should be used for all adults aged 18 and older and the youth tool should be used for all youth between the ages of 12 and 17. Although this GPRA instrument calls for measuring alcohol, tobacco and other drug (ATOD) use and attitudes at project entry, exit, and 6 months and 12 months later, applicants are not required to use the 12 month measure if it is not feasible given their project time lines.

Program Evaluation Methodology: All grant applicants must undertake a process evaluation which documents both their decision making process and implementation efforts and success. In addition, all grantees must respond to four brief questionnaires which will accompany CSAP information packets mailed to grantees during the first 3 months of the project. These questionnaires will focus on obtaining reactions to the perceived informational value and usefulness of the materials enclosed. Grantees will also be responsible for recruiting and performing pre- and post-assessments on 30 families who complete the program implemented during year two. While comparison groups will strengthen the ability to infer that program interventions are effective, they are not required. Follow-up plans and procedures with program non-completers should be planned

for and attempted to help ensure that data from program completers reflect actual change attributable to the program intervention. Again, GPRA and CSAP core measures should be used in pre-post assessments of outcomes and process assessments, while locally developed, should document items of import to CSAP's understanding of the decision making and program implementation process including use of information sources, barriers, steps to overcome barriers and program success.

Data Collection and Analysis: Applicants will be responsible for using the measurement tools associated with the project selected for pre- and post-assessment with a minimum of 30 families completing their intervention. Also, as stated earlier, all applicants must use the GPRA client outcome measures and appropriate CSAP Core Measure Initiative outcome variables and recommended variables. More information about GPRA is provided in Part II under the section with the same name.

A description of the strategies for data collection, processing, clean-up, control, and retention should be included in the application. Process and outcome data collection procedures should be described in regard to how uniform data collection will be ensured, and how participant protection will be assured. The process/implementation data should focus on documenting the decision making process, determining whether the intervention is implemented as planned and lessons learned.

Contribution to the Field

The results of this program should contribute to building the bridge between research and practice by: 1) generating information on how practitioners access and use information on effective strategies and programs; 2) determining procedures and processes local providers go through in selecting an effective intervention for their community; 3) providing information on the type of technical assistance that local programs need in order to implement effective parenting and family intervention models; and 4) determining the types of adaptations required to make interventions culturally appropriate for racially and ethnically diverse families. Thus, awardee participation will help support these goals of advancing the field of substance abuse prevention to further understanding the decision-making process and the initial implementation of a parenting and family intervention within a community-based setting.

Program Design

This cooperative agreement to disseminate information, to assess the adoption of an evidence-based intervention, and to evaluate the implementation of an adopted or adapted intervention tailored to a specific population will be supported in two phases, Year I (Phase I) and Year II (Phase II). The Program Coordinating Center (PCC), funded in FY99 will

assist with program management, study design, training, and data coordination. The PCC is a mechanism used to coordinate training, data collection and analysis among pervious grantees and will be used in a similar manner to support new grantees in the first year of this initiative.

The first program year will be spent in training and technical assistance to help build the grantee's capacity to select, and/or modify effective models to be more culturally appropriate and to pilot test them. The PCC will work with grantees to support their selection of the best parenting program, implementation and evaluation. The second year will be spent in implementing and evaluating the model family program selected so that by the end of the second year at least 30 families will have completed each program and provided complete data in pre-post intervention assessments. Funds may be used for travel and staff time to attend a SAMHSA/CSAP/CMHS new grantee conference and at least one other national parenting or family strengthening conference to preview parenting and family models, as well as to underwrite one 2-3 day training workshop in the model selected. Funds also may be used for consultants and consensus building meetings to select and culturally modify the curriculum or other materials of the program selected. Funds may be used for recruitment and retention costs as well as for staff, materials, and facilities costs to graduate at least 30 families in the selected intervention. Funds can also be used for evaluation support for process and outcome data collection and analysis.

Phase I:

Year I ($ 80,000 - 100,000 Total Funds)

The purpose of this phase of the project is to increase the capacity of local communities to deliver best practices in effective parenting and family programs in order to reduce or prevent substance abuse.

For the first year of this grant SAMHSA/CSAP/CMHS will disseminate information to grantees on available strategies and effective family strengthening models. SAMHSA/CSAP/CMHS will provide technical assistance to grantees: 1) to increase organizational and community readiness for family-focused prevention activities; 2) to help build consensus within the community in the consideration of models culturally and locally appropriate for the target population; 3) in documenting the decision-making process to select a family strengthening model; 4) in the cultural adaptation of the model to the target population, if necessary. Furthermore, SAMHSA/CSAP/CMHS will train staff to implement selected models through the use of regional and national conferences and on-

site technical assistance. SAMHSA/CSAP/CMHS will also provide information on recruitment, cultural and local adaptation of the model, and evaluation, as required. A series of information, training and TA efforts will be provided to the grantees. Examples include: SAMHSA/CSAP's Centers for Application of Prevention Technologies (CAPTs) materials, the National Clearinghouse for Alcohol and Drug Information (NCADI) materials describing various family strengthening intervention programs; information via Info faxes, brochures, literature reviews, websites, manuals or monographs; audio conferences, teleconferences, and regional conferences; and hands-on 2-3 day training in the parenting or family support model selected. Grantees are encouraged also to begin pilot testing the selected and culturally-adapted model program in the last six months of the first year if they are ready to begin. CSAP/CMHS will make every effort to complete the conferences and training workshops in time for grantees to begin implementation as early as possible.

Phase II:

Year II ($ 80,000 - 100,000 Total Funds)

The purpose of this phase of the program is to conduct a field study graduating a total of 30 families in the selected family strengthening intervention model. A minimum of thirty families is required in order to determine a documentable difference measured by pre- and post-tests in family dynamics and children's behaviors and mental status and evaluate whether the program is effective. Requiring the same minimum number of graduates across the sites will facilitate fidelity and reliable analysis. A process and outcome evaluation in this phase will validate adaptations of the models and foster future replications of these adaptations.

Roles

This project will involve the cooperation of 1) the Project Sites, 2) the SAMHSA/CSAP/CMHS Staff, and 3) the Project Coordinating Center (PCC).

Role of Project Sites

As part of the cooperative agreement, collaborative efforts, and the achievement of the program goals, each grantee will be asked: (1) To provide feedback on the content and usefulness of different information dissemination materials and methods to which they are exposed as part of SAMHSA/CSAP/CMHS's information dissemination campaign (Info faxes, brochures, literature reviews, websites, manuals or monographs, audio conferences,

teleconferences, regional parenting and family program showcase conferences, and hands-on 2-3 day training in the parenting or family support model they select); (2) To attend different training and technical assistance sessions provided for the purpose of community capacity building in family strengthening strategies and programs; (3) To participate in developing the criteria that will indicate the achievement of the "decision to adopt" a family strengthening intervention in Phase I, which will then enable implementation in Phase II; and (4) To participate in the development of a cross-site evaluation plan for the model they propose and use SAMHSA/CSAP/CMHS core client outcome measures, as indicated (approved by the Office of Management and Budget (OMB) under control number 0930-0208).

In addition, grantees will be required to submit reporting documents (e.g. progress and fiscal reports). Each Site will be required to submit SAMHSA/CSAP GPRA and core outcome data. Sites also will be required to submit other data, including process measurement data for secondary analysis (on a schedule to be agreed upon). All data collected with this funding will be in the public domain and available for secondary data analysis by CSAP's new Data Coordinating Center (DCC) in order to address critical policy issues.

Role of SAMHSA/CSAP/CMHS Staff

Substantial SAMHSA/CSAP/CMHS staff participation in this program will be required to ensure that the Sites meet the program goals. These Federal staff will also be active participants in all aspects of the cooperative agreement program and will serve as collaborators with the Sites project directors. SAMHSA/CSAP/CMHS staff will have overall responsibility for monitoring the conduct and progress of the Family Strengthening project and will make recommendations regarding its continuance. These staff will provide substantial input, in collaboration with the grantees, both in the planning and conduct of this project. Likewise, they will participate in the publication of the results in order to make findings available to the field.

Section III. PROJECT REQUIREMENTS

All applicants must provide a 5-line, 72 characters per line, summary of their project for later use in publications, reporting to Congress, press releases, etc. should they be funded. This may be the first five lines of the required Project Abstract.

To be considered for this award, all applicants must provide the information specified

below under the proper section headings in the application. The information requested relates to the individual review criteria in Section IV of the GFA.

A. Project Description and Goals

Documentation of Need

- Describe the existing family needs that will be addressed in the targeted community and population. Be sure that the identified issues are relevant both to program goals and target population(s). Provide relevant local data that describes the problem, such as rates of tobacco, alcohol, and illicit drugs, family neglect or abuse data, family risk and protective factors, and population and environmental characteristics relevant to the target population in the area served. The description of use rates should include the type and level of substance use and whether or not the population has been or is in treatment for substance abuse or mental health problems.

Target Population

- Describe the demographics of the target families, including race, gender, ethnicity, and age, numerically and in percentages.

- Describe the target population's risk, protective, or resiliency factors relevant to family issues. If these are people who are limited English speaking or non English speaking, what languages are spoken?

- Provide justification for any exclusions under SAMHSA's Population Inclusion Requirement in Part II.

Purpose and Goals

- Clearly state your project's measurable long term and short term goals and objectives.

- Clearly state how your proposed project activities will address the child and family need(s) that you identified and will achieve the program goals stated in this GFA and in your specific goals.

- Clearly state the expected contributions to the field and community, including innovations, adaptations, and/or the expansion of service capacity.

B. Project Plan

Design
Phase I (Year 1)

- Provide a plan to conduct and document consensus building strategies to select program models under consideration. Include a description of the strategies for involving the target population in all phases of the project, including consensus building, decision-making, implementation, and analysis of the program results.

- Describe how the intervention will be tailored to meet the needs of the target population. This description should include an estimate of the size of the participant pool, how and from what sources the participants will be recruited, enrolled and retained in the project, and how attrition will be handled.

- Describe the process to select, locally adapt, if necessary, and adopt an effective family strengthening model. Document plans for implementation. (Once the decision is made on the selection of a model and training is completed, the grantee may initiate the intervention in the first year and continue to implement it in the second year.) Grantees will select a model after they have received information on the various models available and after they reach consensus on an appropriate model with their constituents. **Applicants are not to describe a specific prevention intervention.**

- Show how HIV/AIDS, alcohol, homeless populations and co-occurring disorders will be addressed when relevant to the chosen site.

Phase II (Year II)

- Describe your organization's capacity to begin implementation of a family strengthening intervention within a year or less, regardless of the model selected, and document the process for graduating a minimum of thirty families.

- Provide a plan to document the cost of implementing the selected model.

- Describe a plan for conducting and evaluating local training to other agencies to help disseminate the parenting or family intervention in the local community.

- Describe a plan to sustain implementation of the intervention without continued federal funding assistance.

C. Project Evaluation

Phase I

Consensus Building Process Evaluation

- Submit a proposed plan for a process evaluation that addresses both the consensus building process and the decisions to select, adapt and adopt or not to adopt. For example, the planning process evaluation could include findings from national and local needs assessment; community, consumer, family, and stakeholder involvement; organizational approaches; barriers and facilitators in the planning process; adaptations made to the intervention to enhance target population outcomes; criteria that are to be used in reaching the "decision to adopt" a family strengthening intervention; "Lessons Learned" and other components.

Phase II

Implementation Process Evaluation

- Submit a proposed plan for an implementation process evaluation, including fidelity to original or modified design. For example, the implementation process could include: findings from the organizational approaches to implement the selected family intervention; staff qualifications, hiring process, training, and supervision; barriers and facilitators related to the implementation of the family strengthening intervention; program service costs and unit costs; accessibility, availability, and utilization assessments; effects of the adaptations to the original design on the target population; and fidelity of the implementation to the modified intervention; and show Lessons Learned.

Outcome Evaluation

- The applicant should propose an Outcome Evaluation plan that will include at a minimum a pre-test conducted immediately prior to client services as an intake and a post-test conducted immediately at discharge from the project services. Additional means to improve the ability of the study design to generate defensible inferences (e.g., a six-month post-test, comparison group) can be proposed, but are not required.

- Provide a plan to document attendance and dosage information, to conduct internal analyses of completers versus non-completers, and to measure outcomes of parents and children. (Grantees are not required to implement a randomized control group or matched control-group design, but are encouraged to do so.)

- Describe a strategy to collect pre- and post-intervention data, including data for those who drop out.

- Describe a strategy to collect data on project outcomes appropriate for the model selected. Applicants should expect to use CSAP's Core Measures related to family outcomes and, five GPRA Measures (age of first use, substance use rates, expectation to use, attitudes about use, and perceived harmfulness of use).

- Describe a dissemination plan to publicize the results to promote advances in family strengthening and integrated substance abuse and prevention to the targeted population.

D. <u>Organizational Capability (Time lines, Organization, Staff, Equipment/Facilities, and Other Support.</u>

Timelines

- Applicants should: 1) describe the expected approach to complete the project on time and within the proposed budget, and 2) complete an Implementation Plan Time Line that includes specific activity, target date for completion, number of participants recruited and completing services, and responsible person.

Organization

- Applicants should provide evidence that their organization has historical success in implementing similar projects with similar target populations, has developed community stakeholder and consumer linkages, can complete the proposed project as reported, and fulfill all the award requirements of this GFA.

Staff

- Describe staffing plan ensuring that staff at all levels of the organization reflect the target population served. Staff at all levels of the organization must have cultural competence training specific to the communities served.

- The applicant should provide a description of the proposed staffing plan including evidence of the qualifications and experience of the proposed project staff to: (1) conduct substance abuse and/or family interventions; (2) demonstrate staff competence in any of the population-specific factors related to age, culture, acculturation, gender, sexual orientation, language, mental health, literacy level; (3) recruit and retain this target population; (4) execute a process and outcome evaluation; and (5) report the results. The staffing plan should also include time lines and rationale for percent of time dedicated to the project as well as ways for documenting staff time dedicated to this cooperative agreement.

Equipment/Facilities

- The applicant should provide evidence that the activities or services are provided in a location/facility that is adequate and accessible, the environment is conducive to the population served, and needed equipment or supplies (i.e., computers, furniture, vans, educational materials, video players and monitors, food, child care needs, etc) will be available. Indicate that space is available to maintain confidentiality when needed.

Other Support

- Applicants should describe other resources needed and how they will facilitate the resources needed for the implementation of this initiative, such as kitchens, dining facilities for meals and wrap-around services to provide basic needs necessary for their projects. They should present a plan for securing resources to sustain program once Federal funding is terminated.

Post-Award Requirement

As part of the cooperative agreement, grantees should participate in all cross-site grantee activities. All publications and written presentations should be included in the reports. Include a dissemination plan to publicize the results to promote advances in family strengthening and integrated substance abuse and prevention to the targeted populations. Dissemination of lessons learned can be achieved through presentations, publications, participation in CSAP/CMHS and other conferences, fact sheets, training and technical assistance to other organizations, and websites. All publications resulting from this effort should clearly identify SAMHSA/CSAP/CMHS as the source of funding.

Each grantee is asked to submit quarterly progress reports in the first year, and semi-annual reports thereafter. Grantees will also be asked to submit a final report.

Section IV. REVIEW OF APPLICATIONS

Guidelines

Applications submitted in response to this GFA will be reviewed for scientific/technical merit in accordance with established PHS/SAMHSA review procedures outlined in the Review Process section I, Part II. Applicants must review the Special Considerations/Requirements and Application Procedures sections that follow, as well as the guidance provided in Part II, before completing their applications.

It is important to note that review criteria A-D below correspond to subsections A-D in the prior Project Requirements section to assist in the application process. The response to each review criterion and each bulleted statement under each criterion should be from the perspective or role of the applicant. Applicants must follow the review criteria headings and bulleted statements which parallel the format of the Program Narrative portion of the application.

Applications will be reviewed and evaluated according to the following review criteria. The points noted for each criterion indicate the maximum number of points the reviewers may assign to that criterion if the application is considered to have sufficient merit for scoring. The assigned points will be used to calculate a raw score that will be converted to the official priority score.

The bulleted statements that follow each review criterion are provided to invite attention to important areas. They serve as a guide for the area(s) applicants must address under each review criterion. These statements do not have weights.

Peer reviewers will be instructed to review and evaluate each criterion in relation to gender, age and cultural competence. Points will be deducted from applications that do not adequately address the cultural aspects of the criteria. See Appendix D in Part II, included in the application kit, for guidelines that will be used to assess cultural competence.

Review Criteria

A. Project Description and Goals (20 points)

Documentation of Need

- Extent to which the application documents existing needs that will be addressed in the targeted community and population.

- The extent to which identified issues are relevant to program goals and to target population(s). The extent to which local data were provided that evidence the problem.

Target Population

- Adequacy of description of the target population's demographics, characteristics, and risk, protective or resiliency factors relevant to family issues.

- Adequacy of justification for any exclusions under SAMHSA's Population Inclusion Requirement in Part II.

Purpose and Goals

- Extent to which the goals include the long-term goal of increasing family resilience, reducing familial substance abuse, and increasing community or

organizational capacity to assist families, as well as more short-term goals of building immediate capacity to implement effective family interventions.

- Extent to which proposed study will add to the knowledge base regarding cultural adaptations of family programs and key components of decision making regarding adoption/adaptation of intervention programming.

- Extent to which there will be contributions made to the field, including innovations, adaptations, and/or the expansion of service capacity.

- Extent to which the applicant recognizes and addresses adequately the importance of modifying or adapting programs of a culturally competent nature.

B. <u>Project Plan</u> (25 points)

Design

Phase I

- Adequacy of the plan to conduct and document consensus building meetings in order to select program models under consideration. Adequacy of the description of the strategies for inclusion of the target population in the consensus building and decision-making phase of the project, implementation, and analysis of the program results.

- Appropriateness of the adaptations made to the intervention in order to meet the needs of the target population. Extent to which the description includes an estimate of the size of the participant pool, how and from where the participants will be recruited, enrolled and retained in the project and how attrition will be handled.

- Appropriateness of the process described to select, locally adapt, if necessary, and adopt an effective family strengthening model, and document plans for implementation.

- Adequacy of the proposal in addressing HIV/AIDS, alcohol, drugs, mental health, homeless populations, and co-occurring disorders if relevant to the selected site.

Phase II

- Adequacy of the organization's demonstrated capacity to implement a family strengthening intervention within a year or less, regardless of the model selected, and the documented process for graduating a minimum of 30 families.

- Adequacy of the plan to document the cost of implementing the selected model.

- Adequacy of the plan for conducting and evaluating local training to other agencies to help disseminate the parenting or family intervention in the local community.

- Adequacy of the plan to sustain implementation of the intervention without federal funding assistance.

- Adequacy of plan to provide competent services, including providing appropriate communications at all points of contact and inclusion of community leaders from each racial/ethnic community served on the advisory board.

C. <u>Project Evaluation</u> (20 points)

Phase I
Consensus Building Process Evaluation

- Adequacy of the proposed plan for a process evaluation that addresses both the consensus building process and the decisions to select, adapt and adopt or not to adopt.

Phase II
Implementation Process Evaluation

- Adequacy of the proposed plan for an implementation process evaluation, including fidelity to original or modified design.

Outcome Evaluation

- Adequacy of the strategy to collect pre- and post-intervention data, including follow-up data for those who drop-out.

- Adequacy of the proposed Outcome Evaluation plan that will include, at a minimum, 1) a pre-test conducted immediately prior to client services as an intake measure 2) a post-test conducted immediately at discharge from the project services 3) five GPRA Measures, and 4) CSAP's Core Outcome Measures.

- Adequacy of the plan to document attendance and dosage information, to conduct internal analyses of completers versus non-completers, and to measure outcomes of parents and children.

D. <u>Organizational Capability (Time lines, Organization, Staff, Equipment/Facilities, and Other Support.</u> (35 points)

Time-line

- Adequacy of the proposed time line, and consistency with the expected approach to complete the project on time and within the proposed budget.

Organization

- Adequacy of the evidence that the organization has historical success in implementing similar projects with similar target populations, has developed community stakeholder and consumer linkages, can complete the proposed project as reported, and can fulfill all the award requirements of this GFA.

Staff

- Adequacy of the proposed staff including evidence of the qualifications and experience of the proposed project staff to: (1) conduct substance abuse and/or family interventions; (2) demonstrate staff competence in any of the population-specific factors related to age, culture, acculturation, gender, sexual orientation, language, mental health, literacy level; (3) recruit and retain this target population; (4) execute a process and outcome evaluation; and (5) report the results. Adequacy of the percent of time dedicated to the project, and of proposed documentation of staff time dedicated to this cooperative agreement.

- Adequacy of staff's experience and qualifications in providing substance abuse violence prevention and family intervention services, recruiting, and retaining this target population**,** including staff's qualifications and competence in the population-specific factors related to age, culture, acculturation, gender, sexual orientation, language, and literacy.

Equipment/Facilities

- Extent to which applicant has demonstrated that the activities or services are to be provided in a location/facility that is adequate and accessible, the environment is conducive to the population served, and needed equipment or supplies will be available. Adequacy of facilities to maintain confidentiality when needed.

Other Support

- Adequacy of other resources needed and how the applicant will secure the resources, such as kitchens, dining facilities for meals and wrap-around services to provide any basic needs necessary for their project. Likewise, applicants should present their plans for securing resources to sustain their program once Federal funding is terminated.

NOTE: Although the reasonableness and appropriateness of the proposed budget for each year of the proposed study is not a review criterion for this GFA, the Initial Review Group will be asked to consider it after the merits of the application have been considered.

Section V. SPECIAL CONSIDERATIONS/REQUIREMENTS

SAMHSA's policies and special considerations/requirements related to this program include:

- SAMHSA's Population Inclusion Requirement
- Government Performance Monitoring
- Healthy People 2000
- Consumer Bill of Rights
- Promoting Non-use of Tobacco
- Supplantation of Existing Funds
- Coordination with Other Federal/Non-Federal Programs
- Single State Agency Coordination
- Intergovernmental Review (E.O. 12372)
- Public Health System Reporting Requirements
- Confidentiality/SAMHSA Participant Protection

Specific guidance and requirements for this application related to these policies and special considerations/requirements can be found in Part II in the section by the same name.

Section VI. APPLICATION PROCEDURES

All applicants must use application form PHS 5161-1 (Rev. 6/99), which contains Standard Form 424 (face page). The following must be typed in Item Number 10 on the face page of the application form: SP 00-002 Family Strengthening.

For more specific information on where to obtain application materials and guidelines, see the Application Procedures section in Part II. Completed applications must be sent to the following address.

SAMHSA Programs
Center for Scientific Review
National Institutes of Health
Suite 1040
6701 Rockledge Drive
Bethesda, MD 20892-7710*

*Applicants who wish to use express mail or courier service should change the zip code to 20817

Complete application kits for this program may be obtained from the National Clearinghouse for Alcohol and Drug Information (NCADI), phone number: 800-729-6686. The address for NCADI is provided in Part II.

APPLICATION RECEIPT AND REVIEW SCHEDULE

The schedule for receipt and review of applications under this GFA is as follows:

Receipt Date	IRG Review	Council Review	Earliest Start Date
June 13, 2000	**July, 2000**	**Sept., 2000**	**Sept., 2000**

Applications must be received by the above receipt date(s) to be accepted for review. An application received after the deadline may be acceptable if it carries a legible proof-of-mailing date assigned by the carrier and the proof-of-mailing date is not later than one week prior to the deadline date. Private metered postmarks are not acceptable as proof of timely mailing. (NOTE: These instructions replace the "Late Applications" instructions found in PHS 5161-1.)

CONSEQUENCES OF LATE SUBMISSION

Applications received after the specified receipt dates will be returned to the applicant without review.

APPLICATION REQUIREMENTS/COMPONENT CHECK LIST

All applicants must follow the requirements and guidelines for developing an application presented in Part I Programmatic Guidance and Part II General Policies and Procedure Applicable to all SAMHSA GFA Documents.

The application should provide a comprehensive framework and description of all aspects of the proposed project. It should be written in a manner that is self-explanatory to reviewers unfamiliar with the prior related activities of the applicant. It should be succinct and well organized, should use section labels that match those provided in the table of contents for the Program Narrative that follows, and must contain all the information necessary for reviewers to understand the proposed project.

To ensure that sufficient information is included for the technical merit review of the application, the Programmatic Narrative section of application must address, but is not

limited to, issues raised in the sections of this document entitled:

1. Program Description
2. Project Requirements
3. Review of Applications

NOTE: It is required that on a separate sheet of paper the name, title, and organization affiliation of the individual who is primarily responsible for writing the application be provided. Providing this information is voluntary and will in no way be used to influence the acceptance or review of the application. When submitting the information, please insert the complete sheet behind the application face page.

A **COMPLETE** application consists of the following components **IN THE ORDER SPECIFIED BELOW**. A description of each of these components can be found in Part II.

__FACE PAGE FOR THE PHS 5161-1 (Standard Form 424 - See Appendix A in Part II for instructions.)

___OPTIONAL INFORMATION ON APPLICATION WRITER (See note above).

__ABSTRACT (not to exceed 30 lines) The first five lines of the abstract should not exceed 72 characters per line, and should adequately summarize the project for later use in publications.

__TABLE OF CONTENTS (include page numbers for each of the major sections of the Program Narrative, as well as for each appendix)

__PROGRAM NARRATIVE (The information requested for sections A-D of the Program Narrative is discussed in the subsections with the same titles in Section II - Program Description, Section III - Project Requirements and Section IV - Review of Applications . **Sections A-D may not exceed 25 single-spaced pages. Applications exceeding these page limits will not be accepted for review and will be returned to the applicant.**)

- __A. Project Description and Goals
- __B. Project Plan (Design)
- __C. Project Evaluation
- __D. Organizational Capability

There are no page limits for the following sections E-H except as noted in H. Biographical Sketches/Job Descriptions. Sections E-H will not be counted toward the 25 page limitation for sections A-D.

___E. Literature Citations (This section must contain complete citations, including titles and all authors, for literature cited in the application).
___F. Budget Justification/Existing Resources/Other Support

___Sections B, C, and E of the Standard Form 424A must be filled out according to the instructions in Part II, Appendix B.

___A line item budget and specific justification in narrative form for the first project year's direct costs AND second year must be provided. Note: SAMHSA/CSAP understands the difficulty in anticipating needed budgets for a program as yet to be selected and for the likely discrepancy in the costs between a planning year and an implementation year. Since both years must be proposed at the same funding level, be sure to consider project savings in Year One that can be carried over to support the extra implementation costs in Year Two. Another possibly strategy would be to plan to begin implementation of at least one cohort in Year One in the last 4-6 months. Additional program costs in Year One could be committed by subcontract for the cultural revisions of the selected program. For contractual costs, provide a similar yearly breakdown and justification for ALL costs (including overhead or indirect costs.

___All other resources needed to accomplish the project for the life of the grant (e.g., staff, funds, equipment, office space) and evidence that the project will have access to these, either through the grant or, as appropriate, through other resources, must be specified.

Other Support ("Other Support" refers to all current or pending support related to this application. Applicant organizations are reminded of the necessity to provide full and reliable information regarding "other support," i.e., all Federal and non-Federal active or pending support. Applicants should be cognizant that serious consequences could result if failure to provide complete and accurate information is construed as misleading to the PHS and could, therefore, lead to delay in the processing of the application. In signing the face page of the application, the authorized representative of the applicant organization certifies that the application information is accurate and complete.

For your organization and key organizations that are collaborating with you in this proposed project, list all currently active support and any applications/proposals pending review or funding that relate to the project. If there are none, state "none." For all active and pending support listed, also provide the following information:

1. Source of support (including identifying number and title).

2. Dates of entire project period.
3. Annual direct costs supported/requested.
4. Brief description of the project.
5. Whether project overlaps, duplicates, or is being supplemented by the present application; delineate and justify the nature and extent of any programmatic and/or budgetary overlaps.

___G. Biographical Sketches/Job Descriptions
A biographical sketch must be included for the project director and for other key positions. Each of the biographical sketches must not exceed **2 pages** in length. In the event that a biographical sketch is included for an individual not yet hired, a letter of commitment from that person must be included with his/her biographical sketch. Job descriptions for key personnel must not exceed **1 page** in length. The suggested contents for biographical sketches and job descriptions are listed in Item 6 in the Program Narrative section of the PHS 5161-1.

___H. Confidentiality/SAMHSA Participant Protection (SPP). The information provided in this section will be used to determine whether the level of protection of participants appears adequate or whether further provisions are needed, according to SAMHSA Participant Protection (SPP). Adequate protection of participants is an essential part of an application and will be considered in funding decisions.

Projects proposed under this announcement may expose participants to risks in as many ways as projects can differ from each other. Following are some examples, but they do not exhaust the possibilities. Applicants should report in this section any foreseeable risks for project participants, and the procedures developed to protect participants from those risks, as set forth below. Applicants should discuss how each element will be addressed, or why it does not apply to the project.

Note: So that the adequacy of plans to address participant protection, confidentiality, and other ethical concerns can be evaluated, the information requested below, which may appear in other sections of the narrative, should be included in this section of the application as well.

1. <u>Protection from Potential Risks</u>:

(a) Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects, besides the confidentiality issues addressed below, which are due either to participation in the project itself, or to the evaluation

activities.

(b) Where appropriate, describe alternative treatments and procedures that might be advantageous to the subjects and the rationale for their non-use.

(c) Describe the procedures that will be followed to minimize or protect participants against potential risks, including risks to confidentiality.

(d) Where appropriate, specify plans to provide needed professional intervention in the event of adverse effects to participants.

2. Equitable selection of participants:

Target population(s):

Describe the sociodemographic characteristics of the target population(s) for the proposed project, including age, gender, racial/ethnic composition, and other distinguishing characteristics (e.g., homeless youth, foster children, children of substance abusers, pregnant women, institutionalized individuals, or other special population groups).

Recruitment and Selection:

(a) Specify the criteria for inclusion or exclusion of participants and explain the rationale for these criteria.

(b) Explain the rationale for the use of special classes of subjects, such a pregnant women, children, institutionalized mentally disabled, prisoners, or others who are likely to be vulnerable.

(c) Summarize the recruitment and selection procedures, including the circumstances under which participation will be sought and who will seek it.

3. Absence of Coercion:

(a) Explain whether participation in the project is voluntary or mandatory. Identify any potentially coercive elements that may be present (e.g., court orders mandating individuals to participate in a particular intervention or treatment program).

(b) If participants are paid or awarded gifts for involvement, explain the remuneration process.

(c) Clarify how it will be explained to volunteer participants that their involvement in the study is not related to services and the remuneration will be given even if they do not complete the study.

4. Appropriate Data Collection:

(a) Identify from whom data will be collected (e.g., participants themselves, family members, teachers, others) and by what means or sources (e.g., school records, personal interviews, written questionnaires, psychological assessment instruments, observation).

(b) Identify the form of specimens (e.g., urine, blood), records, or data. Indicate whether the material or data will be obtained specifically for evaluative/research purposes or whether use will be made of existing specimens, records, or data. Also, where appropriate, describe the provisions for monitoring the data to ensure the safety of subjects.

(c) Provide, in Appendix No.5, entitled "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that will be used or proposed to be used in the case of cooperative agreements.

5. Privacy and Confidentiality:

Specify the procedures that will be implemented to ensure privacy and confidentiality, including by whom and how data will be collected, procedures for administration of data collection instruments, where data will be stored, who will/will not have access to information, and how the identity of participants will be safeguarded (e.g., through the use of a coding system on data records; limiting access to records; storing identifiers separately from data).

Note: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records in accordance with the provisions of Title 42 of the Code of Federal Regulations, Part 2 (42 CFR, Part 2).

6. Adequate Consent Procedures:

(a) Specify what information will be provided to participants regarding the nature and purpose of their participation; the voluntary nature of their participation; their right to withdraw from the project at any time, without prejudice; anticipated use of data; procedures for maintaining confidentiality of the data; potential risks; and

procedures that will be implemented to protect participants against these risks.

(b) Explain how consent will be appropriately secured for youth, elderly, low literacy and/or for those who English is not their first language.

Note: If the project poses potential physical, medical, psychological, legal, social, or other risks, awardees may be required to obtain written informed consent.

(c) Indicate whether it is planned to obtain informed consent from participants and/or their parents or legal guardians, and describe the method of documenting consent. For example: Are consent forms read to individuals? Are prospective participants questioned to ensure they understand the forms? Are they given copies of what they sign?

Copies of sample (blank) consent forms should be included in Appendix No. 6, entitled "Sample Consent Forms." If appropriate, provide English translations.

Note: In obtaining consent, no wording should be used that implies that the participant waives or appears to waive any legal rights, is not free to terminate involvement with the project, or releases the institution or its agents from liability for negligence.

(d) Indicate whether separate consents will be obtained for different stages or aspects of the project, and whether consent for the collection of evaluative data will be required for participation in the project itself. For example, will separate consent be obtained for the collection of evaluation data in addition to the consent obtained for participation in the intervention, treatment, or services project itself? Will individuals not consenting to the collection of individually identifiable data for evaluative purposes be permitted to participate in the project?

7. Risk/Benefit Discussion:

Discuss why the risks to subjects are reasonable in relation to the anticipated benefits to subjects and in relation to the importance of the knowledge that may reasonably be expected to result.

__APPENDICES (Only the appendices specified below may be included in the application. **These appendices must not be used to extend or replace any of the required sections of the Program Narrative.** The total number of pages in the appendices **CANNOT EXCEED 30 PAGES,** excluding all instruments.)

__Appendix 1: Eligibility Certification Documents

___Appendix 2: Letters of Coordination/Support
___Appendix 3: Copy of Letter(s) to SSA(s)
___Appendix 4: Organizational Structure/Timeline/Staffing Patterns
___Appendix 5: Data Collection Instruments/Interview Protocols
___Appendix 6: Sample Consent Forms

___ASSURANCES NON-CONSTRUCTION PROGRAMS (STANDARD FORM 424B)

___CERTIFICATIONS

___DISCLOSURE OF LOBBYING ACTIVITIES

TERMS AND CONDITIONS OF SUPPORT

For specific guidelines on terms and conditions of support, allowable items of expenditure and alterations and renovations, applicants must refer to the sections in Part II by the same names. In addition, in accepting the award the Grantee agrees to provide SAMHSA with GPRA Client Outcome (if applicable) and Evaluation Data.

Reporting Requirements

For the SAMHSA policy and requirements related to reporting, applicants must refer to the Reporting Requirements section in Part II.

Lobbying Prohibitions

SAMHSA's policy on lobbying prohibitions is applicable to this program; therefore, applicants must refer to the section in Part II by the same name.

AWARD DECISION CRITERIA

Applications will be considered for funding on the basis of their overall technical merit as determined through the IRG and the CSAP and the CMHS National Advisory Council review process.

Other award criteria will include:

- Availability of funds.
- Overall program balance in terms of geography (including rural/urban areas), race/ethnicity of proposed project population, and project size.

- Certification of formal coordination/collaboration with a Federal and/or non-Federal organization that has the recognized capacity to provide collaborative intervention services.

- Evidence of nonsupplantation of funds.

CONTACTS FOR ADDITIONAL INFORMATION

Questions concerning program issues may be directed to:

Rose Kittrell, Acting Team Leader
High Risk Youth/Replication Team
Division of Knowledge Development and Evaluation
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration
Rockwall II, Room 1075
5600 Fishers Lane
Rockville, MD 20857
(301) 443-0353
Technical Assistance Line: (301) 443-6612

Anne Mathews-Younes, Ed.D.
Chief, Special Programs Branch
Division of Program Development/ Special Populations and Projects
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Parklawn Building, Room 17-C17
5600 Fishers Lane
Rockville, MD 20857
(301) 443-0554

Questions regarding grants management issues may be directed to:

Edna Frazier
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration
Rockwall II, Room 630
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-6816

Appendix A. REFERENCES

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Appendix B. MATRIX OF POTENTIAL PROGRAMS

Name	Type	Level
1. Adolescent Transitions Program	Comprehensive	Selective
2. Brief Strategic Family Therapy	Family Therapy	Indicated
3. Creating Lasting Family Connections	Comprehensive	Selective
4. DARE to be You	Family skills training	Selective
5. Effective Black Parenting Program	Parent training	Selective
6. Families and Schools Together (FAST)	Comprehensive	Selective
7. Focus on Families	Family skills training	Indicated
8. Functional Family Therapy	Family Therapy	Indicated
9. Healthy Families Indiana	Comprehensive	Selective
10. Helping the Noncompliant Child	Parent Training	Indicated
11. HOMEBUILDERS	Comprehensive	Indicated
12. Minnesota Early Learning Design (MELD)	Parent Training	Universal
13. Multidimensional Family Therapy	Family Therapy	Indicated
14. Nurturing Parenting Program	Parent Training	Selective
15. Nurturing Program for Families: Substance Abuse Treatment & Recovery	Parent Training	Indicated
16. Parenting Adolescents Wisely	Family Skills Training	Indicated
17. Parent Project	Parent Training	Universal
18. Parents as Teachers	Parent Training	Universal
19. Parents Who Care	Family skills training	Selective
20. Preparing for the Drug-free Years	Parent training	Universal
21. Project SEEK (Services to Enable and Empower Kids)	Comprehensive	Indicated
22. Raising a Thinking Child: I Can Problem Solve	Parent training & Children's skills	Universal
23. Strengthening Families Program	Parent training & Children's skills	Selective
24. Strengthening Families Program for Parents and Youth	Family skills training	Universal
25. Strengthening Hawaii's Families	Parent training	Selective
26. Strengthening Multi-Ethnic Families and Communities	Parent Training	Selective
27. The Incredible Years	Comprehensive	Selective
28. Treatment Foster Care	Family in-home support	Indicated

Note: Comprehensive models include more than one intervention strategy with family members.

Appendix C. SOURCES FOR EFFECTIVE FAMILY STRENGTHENING

Effective family strengthening programs recommended were selected from various sources, including:

- Ashery, R. S., Robertson, E., & Kumpfer, K.L. (Eds.) (1999). Drug Abuse Prevention Through Family Interventions. NIDA Research Monograph #177, DHHS, NIDA, Rockville, MD, NIH Publication 97-4135.

- Brounstein, P. & Zweig, J.M. (1998). Understanding Substance Abuse Prevention--Toward the 21st Century: A Primer on Effective Programs. SAMHSA/Center for Substance Abuse Prevention. Division of Knowledge Development and Evaluation.

- Kumpfer, K. L., & Alvarado, R. (November, 1998) *Juvenile Justice Bulletin.* Family Strengthening Series. US. Department of Justice. Office of Juvenile Justice and Delinquency Prevention. JJ Clearinghouse.

- Preventing Substance Abuse Among Children and Adolescents: Family-Centered Approaches (Prevention Enhancement Protocol Systems (PEPS)). SAMHSA/Center for Substance Abuse Prevention. DHHS Publication No. (SMA) 3223-FY98.

Appendix D. CSAP GPRA CLIENT OUTCOME MEASURES FOR DISCRETIONARY PROGRAMS

Form Approved
OMB No. 0930-0208
Expiration Date: 10/31/2002

CSAP GPRA Client Outcome Measures for Discretionary Programs

ADULT TOOL

RECORD MANAGEMENT

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|____|____|

Grant Year |____|____|
Year

Interview Date |____|____| / |____|____| / |____|____|

Interview Type **1. PRETEST 2. POST-TEST**
3. 6 MONTH FOLLOW-UP 4 . 12 MONTH FOLLOW-UP

DEMOGRAPHICS (QUESTIONS 1-4 ASKED ONLY AT BASELINE)

1. Gender

- O **Male**
- O **Female**
- O **Other (please specify) _____**

2. Are you Hispanic or Latino?

O **Yes** O **No**

3. What is your race?

- O **Black or African American**
- O **Asian**
- O **American Indian**
- O **Native Hawaiian or other Pacific Islander**
- O **Alaska Native**
- O **White**
- O **Other (Specify)_____**

4. What is your date of birth |____|____| / |____|____| / |____|____|
Month / Day / Year

DRUG AND ALCOHOL USE

1. During the past 30 days how many days have you used the following: **Number of Days**

a. **Any alcohol** |____|____|

b. **Alcohol to intoxication (5+drinks in one setting)** |____|____|

c. **Other illegal drugs** |____|____|

2. During the past 30 days how many day have you used any of the following: **Number of Days**

a. **Cocaine/Crack** |____|____|

b. **Marijuana/Hashish, Pot** |____|____|

c. **Heroin or other opiates** |____|____|

d. **Non prescription methadone** |____|____|

e. **PCP or other hallucinogens/ psychedelics, LSD, Mushrooms, Mescaline** |____|____|

f. **Methamphetamine or other amphetamines, Uppers** |____|____|

g. **Benzodiazepines, barbiturates, other tranquilizers, Downers, sedatives, or hypnotics** |____|____|

h. **Inhalants, poppers, rush, whippets** |____|____|

i. **Other Drugs--Specify_____** |____|____|

3. Now think about the past 30 days-That is from *DATEFILL* up to and including today. During the past 30 days, have you smoked part or all of a cigarette?

○ Yes ○ No

4. During the past 30 days, that is since *DATEFILL*, on how many days did you use chewing tobacco?

_____# of Days

5. Now think about the past 30 days-That is from *DATEFILL* up to and including today. During the past 30 days, have you used snuff, even once?

○ Yes ○ No

6. Now think about the past 30 days-That is from *DATEFILL* up to and including today. During the past 30 days, have you smoked part or all of any type of cigar?

○ Yes ○ No

7. During the past 30 days, that is since DATEFILL, have you smoked tobacco in a pipe, even once?

○ Yes ○ No

8. How old were you the first time you smoked part or all of a cigarette?

_____ years old

If never smoked all or part of a cigarette please mark the box 9

9. Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink.

AGE: _____

If never had a drink of an alcoholic beverage please mark the box 9

10. How old were you the first time you used marijuana or hashish?

AGE: _____

If never used marijuana or hashish please mark the box 9

11. How old were you the first time you used any other illegal drugs?

AGE: _____

If never used illegal drugs please mark the box 9

ATTITUDES AND BELIEFS

1. How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?

○ No risk

- ○ Slight risk
- ○ Moderate risk
- ○ Great risk

2. How much do people risk harming themselves physically and in other ways when they smoke marijuana once a month?

- ○ No risk
- ○ Slight risk
- ○ Moderate risk
- ○ Great risk

3. How much do people risk harming themselves physically and in other ways when they:

a. Have four or five drinks of an alcoholic beverage nearly every day?

- ○ No risk
- ○ Slight risk
- ○ Moderate risk
- ○ Great risk

b. Have five or more drinks of an alcoholic beverage once or twice a week?

- ○ No risk
- ○ Slight risk
- ○ Moderate risk
- ○ Great risk

4. How do you feel about adults smoking one or more packs of cigarettes per day?

- ○ Neither approve nor disapprove
- ○ Somewhat disapprove
- ○ Strongly disapprove

5. How do you feel about adults trying marijuana or hashish one or twice?

- ○ Neither approve nor disapprove
- ○ Somewhat disapprove
- ○ Strongly disapprove

6. How do you feel about adults having one or two drinks of an alcoholic beverage nearly every day?

- ○ Neither approve nor disapprove
- ○ Somewhat disapprove
- ○ Strongly disapprove

7. How do you feel about adults driving a car after having one or two drinks of an alcoholic beverage?

- ○ Neither approve nor disapprove

○ Somewhat disapprove
○ Strongly disapprove

EDUCATION, EMPLOYMENT, AND INCOME

1. What is the highest level of education you have finished, whether or not you received a degree? [01=1st grade, 12=12th grade, 13=college freshman, 16=college completion]

|____|____| level in years

1a. If less than 12 years of education, do you have a GED (Graduate Equivalent Diploma)?

○ Yes ○ No

YOUTH TOOL
(12 years old and over)

RECORD MANAGEMENT

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|____|____|

Grant Year |____|____|
Year

Interview Date |____|____| / |____|____| / |____|____|

Interview Type
1. **PRETEST**
2. **POST-TEST**
3. **6 MONTH FOLLOW-UP**
4. **12 MONTH FOLLOW-UP**

DEMOGRAPHICS (QUESTIONS 1-4 ASKED ONLY AT BASELINE)

1. Gender

- ○ Male
- ○ Female
- ○ Other (please specify) _____

2. Are you Hispanic or Latino?

○ Yes ○ No

3. What is your race?

- ○ Black or African American
- ○ Asian
- ○ American Indian
- ○ Native Hawaiian or other Pacific Islander
- ○ Alaska Native
- ○ White
- ○ Other (Specify)_____

4. What is your date of birth |____|____| / |____|____| / |____|____|
Month / Day / Year

DRUG AND ALCOHOL USE

1. During the past 30 days how many days have you used the following: **Number of Days**

a. **Any alcohol** |____|____|

b. **Alcohol to intoxication (5+drinks in one setting)** |____|____|

c. **Other illegal drugs** |____|____|

2. During the past 30 days how many day have you used any of the following: **Number of Days**

a. **Cocaine/Crack** |____|____|

b. **Marijuana/Hashish, Pot** |____|____|

c. **Heroin or other opiates** |____|____|

d. **Non prescription methadone** |____|____|

e. **PCP or other hallucinogens/ psychedelics, LSD, Mushrooms, Mescaline** |____|____|

f. **Methamphetamine or other amphetamines, Uppers** |____|____|

g. **Benzodiazepines, barbiturates, other tranquilizers, Downers, sedatives, or hypnotics** |____|____|

h. **Inhalants, poppers, rush, whippets** |____|____|

i. **Other Drugs--Specify_____** |____|____|

3. Now think about the past 30 days-That is from *DATEFILL* up to and including today. During the past 30 days, have you smoked part or all of a cigarette?

O **Yes** O **No**

4. During the past 30 days, that is since *DATEFILL*, on how many days did you use chewing tobacco?

_____# of Days

5. **Now think about the past 30 days-That is from *DATEFILL* up to and including today. During the past 30 days, have you used snuff, even once?**

O **Yes** O **No**

6. **Now think about the past 30 days-That is from *DATEFILL* up to and including today. During the past 30 days, have you smoked part or all of any type of cigar?**

O **Yes** O **No**

7. **During the past 30 days, that is since DATEFILL, have you smoked tobacco in a pipe, even once?**

O **Yes** O **No**

8. **On how many occasions (if any) have you had alcohol to drink-more than just a few sips?**

- O **Never**
- O **1-2**
- O **3-5**
- O **6-9**
- O **10-19**
- O **20-39**
- O **40 or more**

9. **How old were you the first time you smoked part or all of a cigarette?**

_____ years old
If never smoked part or all of a cigarette please mark the box 9

10. **Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink.**

AGE: _____
If never had a drink of an alcoholic beverage please mark the box 9

11. **How old were you the first time you used marijuana or hashish?**

AGE: _____
If never used marijuana or hashish please mark the box 9

12. **How old were you the first time you used any other illegal drugs?**

AGE: _____
If never used any illegal drugs please mark the box 9

FAMILY AND LIVING CONDITIONS

1. During the past 30 days how stressful have things been for you because of your use of alcohol or other drugs?

- O **Not at all**
- O **Somewhat**
- O **Considerably**
- O **Extremely**

2. During the past 30 days has your use of alcohol or other drugs caused you to reduce or give up important activities?

- O **Not at all**
- O **Somewhat**
- O **Considerably**
- O **Extremely**

3. During the past 30 days has your use of alcohol and other drugs caused you to have emotional problems?

- O **Not at all**
- O **Somewhat**
- O **Considerably**
- O **Extremely**

ATTITUDES AND BELIEFS

1. It is clear to my friends that I am committed to living a drug-free life.

- O **False**
- O **Maybe**
- O **True**

2. I have made a final decision to stay away from marijuana.

- O **False**
- O **Maybe**
- O **True**

3. I have decided that I will smoke cigarettes.

- O **False**
- O **Maybe**
- O **True**

4. I plan to get drunk sometime in the next year.

- O **False**
- O **Maybe**
- O **True**

5. How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?

- O **No risk**
- O **Slight risk**
- O **Moderate risk**
- O **Great risk**
- O **Can't Say/Drug Unfamiliar**

6. How much do people risk harming themselves physically and in other ways when they smoke marijuana once a month or more?

- O **No risk**
- O **Slight risk**
- O **Moderate risk**
- O **Great risk**
- O **Can't Say/Drug Unfamiliar**

7. How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?

- O **No risk**
- O **Slight risk**
- O **Moderate risk**
- O **Great risk**
- O **Can't Say/Drug Unfamiliar**

8. How much do you think people risk harming themselves physically and in other ways when they have four or more drinks of an alcoholic beverage nearly everyday?

- O **No risk**
- O **Slight risk**
- O **Moderate risk**
- O **Great risk**
- O **Can't Say/Drug Unfamiliar**

9. How much do you think people risk harming themselves physically and in other ways when they have four or more drinks of an alcoholic beverage once or twice a week?

- O **No risk**
- O **Slight risk**
- O **Moderate risk**
- O **Great risk**
- O **Can't Say/Drug Unfamiliar**

10. How wrong do you think it is for someone your age to drink beer, wine or hard liquor (for example, vodka, whiskey or gin) regularly?

- O **Very wrong**
- O **Wrong**
- O **A little bit wrong**
- O **Not wrong at all**

11. How wrong do you think it is for someone your age to smoke cigarettes?

- O **Very wrong**
- O **Wrong**
- O **A little bit wrong**
- O **Not wrong at all**

12. How wrong do you think it is for someone your age to smoke marijuana?

- O **Very wrong**
- O **Wrong**
- O **A little bit wrong**
- O **Not wrong at all**

13. How wrong do you think it is for someone your age to use LSD, cocaine, amphetamines or another illegal drug?

- O **Very wrong**
- O **Wrong**
- O **A little bit wrong**
- O **Not wrong at all**

EDUCATION, EMPLOYMENT, AND INCOME

1. What is the highest level of education you have finished, whether or not you received a degree? [01=1st grade, 12=12th grade, 13=college freshman, 16=college completion]

|____|____| level in years

1a. If less than 12 years of education, do you have a GED (Graduate Equivalent Diploma)?

○ Yes ○ No

Appendix E. TABLE OF CORE MEASURES DOMAINS, CONSTRUCTS, AND INSTRUMENTS

Domain Code	Construct Name	Sub-Construct Scale	Instrument Name	Version
Family	Family Conflict		Student Survey of Risk and Protective Factors	98
	Family Cohesion		Family Relations Scale	
	Parent/Child Bonding	Parent-Child Affective Quality (Parent Report)	Parent-Child Affective Quality	
	Parent/Child Bonding	Family Attachment Scale	Student Survey of Risk and Protective Factors	98
	Family ATOD Use/ History of Use	Family History of Antisocial Behavior	Student Survey of Risk and Protective Factors	98
	Family ATOD Use/ History of Use	Family History of AOD Problems	FIPSE Core Alcohol and Drug Survey	1989-1993
	Parenting Practices	Poor Family Management	Student Survey of Risk and Protective Factors	98
	Parenting Practices	Poor Discipline	Student Survey of Risk and Protective Factors	98
	Family Composition		Capable Families and Youth Family Form	Fall 1998
	Perceived Parental Attitudes Toward Youth ATOD Use		Student Survey of Risk and Protective Factors	98
	Family Involvement	Opportunities for Prosocial Involvement	Student Survey of Risk and Protective Factors	98
	Family Involvement	Rewards for Prosocial Involvement	Student Survey of Risk and Protective Factors	98
	Decision Making/ Problemsolving		In progress	
	Family Coping Styles		In progress	
	Family Ethnic Identity		In progress	
	Family Stress		In progress	

Domain Code	Construct Name	Sub-Construct Scale	Instrument Name	Version
	Poverty		In progress	
	Resources/Opportunity Structures		In progress	
	Social Support		In progress	

Appendix F: RESOURCE INFORMATION FOR FAMILY STRENGTHENING

Adolescent drug abuse increased for eight years before leveling off or declining in the last few years (Johnston, Bachman, & O'Malley, 1999; SAMHSA, 1999). A recent study finds drug-abusing youth are also engaging in aggressive, violent, and delinquent behaviors (DHHS/SAMHSA, 1998). Recent longitudinal research suggests that parents have a larger impact on their adolescent's behaviors than previously thought (Resnick, et al., 1997). Although peer influence is the major reason adolescents initiate negative behaviors (Kumpfer & Turner, 1990/1991; Newcomb, 1995; Oetting, 1992), recent CSAP high risk youth data analyses reveal that positive parent/child relationships, parental monitoring, and family and peer disapproval of inappropriate behaviors and drug use set the stage early and are major reasons youth do not initiate drug use (Sambrano, Springer, Sales, Turner & Herman, 1998), or engage in violent, delinquent or unhealthy behaviors (Ary, Duncan, Biglan, Metzler, Noell, & Smolkowski, in press; Coombs, Paulson, & Richardson, 1991).

The need for initiatives to reduce substance abuse and violence and enhance resilience is driven, in part, by the dramatic effects of youth violence over the past decade and by the fact that this violence has become more lethal. While the homicide rate for most other age groups fell, the homicide rate for adolescents doubled, and nonfatal violent crimes committed by adolescents increased nearly 20 percent (Elliott, Hamburg, and Williams, 1998). Fights that, in earlier years, resulted in black eyes, bloody noses or minor bruises now often involve a death or serious injury. During the 1992–93 and 1993–94 school years combined, 76 students were murdered or committed suicide at school and an additional 20 nonstudents were killed at school (National Center for Educational Statistics, 1998).

Homicide and suicide, both preventable, rank as the third and fifth leading causes of death for children 5 to 14 years of age (Anderson et al., l997). While death rates from unintentional injuries decreased more than 40 percent among school-age children between l979 and l995, death rates from both homicide and suicide increased (Anderson et al., l997). Intentional injuries are the fourth leading cause of years of potential life lost, that is, the number of productive years an individual has lost because of premature death before the age of 65.

More than a generation of research has provided a solid knowledge base of the complex risk processes that lead to both substance abuse and violent outcomes for children, families, schools, and communities. Drug abuse and antisocial behaviors of children and adolescents at highest risk arise from the interaction of multiple environmental and individual antecedents that begin early in the child's life. They include (1) **stressful family environments, (2) lack of parenting skills,** (3) alienation between family and school (and other community institutions), and (4) individual characteristics of the child that may be biologically based (e.g., irritability, impulsivity), and interfere with critical early attachment and nurturing relationships and later make the child's behavior difficult to control.

This results in the early onset of substance abuse, conduct disorders and aggressive behaviors, the increase of behavior problems at home, and the continuation and escalation of problems with peers and teachers when the child reaches school age. Unless interrupted, these antisocial behaviors can persist throughout the school career and on into adulthood. High risk intensifies in middle school and accelerates into later adolescence. Risk is exacerbated by exposure to negative peer pressure and a noxious environment where few protective factors are available. These, in turn, increase the likelihood of interpersonal violence and other antisocial behavior, substance abuse, potential drug dealing, addiction, the emergence of disorders such as depression and anxiety, suicidal behaviors, academic failure, risky sexual behaviors leading to increased risk for HIV and other sexually transmitted diseases, and teen pregnancy.

Reviews of the research literature (Ashery, Robertson, & Kumpfer, SAMHSA/CSAP/PEPS, 1998; Kazdin, 1995; Kumpfer, 1993, 1997; Kumpfer & Alvarado, 1995; 1998; Serketich & Dumas, 1996; Taylor & Biglan, 1998) have identified many different parenting and family strengthening programs effective in improving parenting and reducing adolescent problem behaviors. Unfortunately, few of these effective programs are being disseminated widely or are locally tailored for diverse racial/ethnic populations. Needed now to help bridge the gap between research and practice are more applications on how to encourage practitioners to adopt/adapt these "best practices." Therefore, SAMHSA/CSAP/CMHS propose to fund providers to implement effective approaches, by supporting information dissemination and nationwide training and technical assistance. This action will increase the provider's capacity to adapt and implement effective family strengthening prevention programs with fidelity and with attention to local and cultural needs. In this regard, among family interventions identified as effective are those targeting African-American and diverse Hispanic populations (e.g., Cuban, Mexican, Puerto Rican), as well as those targeting Asian American and Pacific Islander populations.

CSAP's Family Prevention Enhancement Protocol System (PEPS/CSAP, 1998) identified approximately 50 research-based parenting and family intervention models. Subsequently, an expert review identified 28 for dissemination to the FY99 Parenting and Family Strengthening Program grantees. Over the course of the first year of this effort, funded grantees will be asked to work towards selecting the most age- and culturally-appropriate program from this group for implementation in this project. Information provided by the grantees will determine which information dissemination methods work best in helping

them to select and culturally tailor these effective models, and to implement and evaluate them with fidelity as gender-, developmentally-, and culturally-adapted. The model programs identified have developed training materials and protocols and can be engaged by individual programs or in regional meetings to provide training in universal, selective, and indicated primary prevention parenting and family programs that are appropriate for families from many different racial/ethnic groups with children from birth to 18 years of age. Many of these evidence-based parenting programs were developed to improve mental, emotional and behavioral problems in children already manifesting conduct disorders and depression, which are common precursors of later substance abuse, violence and negative mental health outcomes. A number of these programs were developed specifically for families from different ethnic or racial groups or for multi-ethnic families, poor families, single parent families, foster families and families with alcohol or drug-abusing parents. Some programs were developed specifically for Spanish-speaking families and have been modified to target specific groups within the Spanish language versions generated (e.g., Cuban). Some have Asian language materials. CSAP's current grantees are developing more language versions including those for various Native American and Alaskan Eskimo cultures.

While a specific intervention should not identified as part of the application, a sample of universal, selective, or indicated populations and prevention interventions are provided in Appendix E. Universal prevention interventions are designed for all families, while selective interventions are for families with youth at especially high risk of *violence*, developing substance abuse problems and/or for youth in families in which substance abuse is occurring. Indicated interventions are for those families with identified problems in the family or the child (e.g., physical and mental disorders and/or learning and conduct disorders) that have brought them to the attention of social services, welfare, mental health, substance abuse, the juvenile justice system, and/or the drug courts. Grant applicants could also choose to focus on specific population groups that have not been included previously for such interventions, such as specific racial/ethnic subgroups, rural and/or suburban families, or homeless families.

Effective Family Strengthening Approaches. A large number of effective parenting and family programs have been developed and evaluated over the past 25 years, including culturally-adapted approaches (Ashery et al., 1998). The SAMHSA/CSAP PEPS(1998) review of family-focused approaches has determined that the three approaches listed below currently have the highest level of evidence of effectiveness in reducing behavioral and emotional problems in youth, namely:

1) behavioral parent training,
2) family skills training (which combines parent training, children's skills training, and family relationship enhancement and communication practice sessions), and
3) structural or behavioral family therapy.

A fourth approach, in-home family support, while not meeting the highest level of evidence of effectiveness, did reach the "medium" level of evidence of effectiveness. Many studies

are currently validating this model, so this approach is included in the recommended approaches. Some programs combine more than one of these approaches and include additional auxiliary support services. These programs are called "comprehensive" approaches. Although all of the above models have been implemented in a variety of settings with different populations, further testing and adapting of each model is needed to enhance cultural appropriateness. Enhancing cultural appropriateness of these approaches is a primary focus of this initiative.

A description of these science-based approaches follows.

Behavioral Parent Training. This highly structured universal or selective prevention approach (Mrazek & Haggerty, 1994) includes parents only, generally in small groups led by a skilled trainer or clinician. The information follows a curriculum guide covering at least 12 one to two hour sessions. Sessions include review of homework; VHS video presentations of effective and ineffective ways of parenting; short lectures and discussions to identify parenting principles; interactive exercises; role plays of direct practice in the parenting behavior to be changed; charting and monitoring of parenting and children's behavior and assignment of homework.

Family Skills Training or Behavioral Family Therapy. This universal, selective, or indicated multi-component prevention approach combines: 1) behavioral parent training; 2) children's social and life skills training; and 3) family relationship enhancement and communication practice sessions. Recruitment and retention of participants is sometimes better with this approach; the children encourage the parents to sign up or stay in the program because they do not want to miss their friends. Contents of the children's skills training program often include: identification of feelings; anger and emotional management; accepting and giving feedback and criticism or praise; problem solving; decision making; assertion and peer resistance skills; communication skills and how to make and keep positive friends. Food, transportation, and child care are often provided.

Family Therapy. This indicated prevention approach is typically implemented with youth diagnosed as having milder emotional or behavioral problems such as conduct disorder, depression, and school or social problems that if not treated can lead to more severe problems such as delinquency or drug use. They are conducted by trained clinicians or interns under supervision in a clinic.

In-home Family Support. This approach provides a wide range of family services through in-home case management, combined with parenting training and in-home advice and parent education.

Comprehensive Approaches. These approaches combine parenting and family support with community environmental changes, and integrated behavioral health and mental health services. Generally, the intervention is provided through the coordination of a case manager.

Because sufficient research has been conducted in family strengthening approaches to determine evidence-based practices, SAMHSA/CSAP/CMHS is committed to these effective programs and promoting their widespread adoption. Therefore, SAMHSA/CSAP/CMHS will fund Knowledge Application cooperative agreements to support translation of research to practice and field testing of effectiveness, through this GFA.